STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155336		A. BUII	LDING	ONSTRUCTION 00	(X3) DATE COMPL	ETED	
NAME OF PROVIDER OR SUPPLIER  DECATUR TOWNSHIP CARE AND REHABILITATION CENTE		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE INCHER ROAD IAPOLIS, IN46221			
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID	T		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	DATE
F0000							
l l		the Investigation of	F0	000			
	Complaint IN000	088825.					
	Complaint IN000	088825 - Substantiated.					
	Federal/state defi	ciencies related to the					
	allegations are ci	ted at F323 and F9999.					
	Survey dates: Ap	oril 18 & 19, 2011					
	Facility number:						
	Provider number	: 155336					
	AIM number: 10	00266850					
	Survey team: Joy	yce Hofmann, RN					
	Census bed type:						
	SNF/NF: 71						
	Total: 71						
	Census payor typ	e:					
	Medicare: 7						
	Medicaid: 48						
	Other: 16						
	Total: 71						
	Sample: 3						
	This deficiency a in accordance wi	lso reflects state findings th 410 IAC 16.2.					
	Quality review 4/ Williams, RN	/26/11 by Suzanne					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000229

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155336	B. WIN			04/19/2	011
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	£		4851 T	INCHER ROAD		
	R TOWNSHIP CAR	RE AND REHABILITATION CENT	ER	INDIAN	IAPOLIS, IN46221	-	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
F0323	•	ensure that the resident ains as free of accident					
		sible; and each resident					
	receives adequate						
	assistance device	s to prevent accidents.					
SS=G	Based on observ	ation, interview, and	F0	323	"This Plan of Correction is		05/09/2011
	record review, th	ne facility failed to			prepared and submitted as		
	adequate supervi	ise and implement			required by law. By		
	interventions to p	prevent a resident who			submitting this Plan of		
	was declining in	condition and at risk for			Correction, Decatur Care	&	
	falls from falling	and receiving a			Rehabilitation Center doe	s	
	significant head	injury, for 1 of 3 residents			not admit that the deficience	v	
	-	s in a sample of 3.			listed on this form exist, no		
	[Resident #B]				does the Center admit to an		
					statements, findings, facts,	·	
	Findings include	•			conclusions that form the ba		
	1 mamgs merade	•			for the alleged deficiency.		
	Resident #B was	s observed on 04/18/2011			Center reserves the right to	1110	
		be in a geri chair near the			challenge in legal and/or		
		the common area on the			regulatory or administrative		
		resident was observed to			proceedings the deficiency,	,	
		uise around her right eye			statements, facts, and		
	_				1 ' '		
	and right cheek b	oone.			conclusions that form the ba	asis	
	Turin to 181 st	and American Discourse C			for the deficiency."		
		ne Assistant Director of			-		
		on 04/18/2011 at 10:35			-		
		esident #B had fallen			-		
		as ago and was sent to the			_F-323		
	_	intracranial hemorrhage.			1. Resident B was re-assessed	-	
	The ADoN indic	ated the resident was a			a licensed nurse on 3/28/11 post	tall	
	Hospice resident	, was not interviewable,			in which the nurse provided 1:1 supervision for 10 minutes post f	all	
	had dementia and	d breast cancer, and was			until the resident was transported		
	total care.				emergency room for evaluation a		
					treatment. The licensed nurse th		
	Resident #B's cli	inical record was			implemented a pressure reducing	;	

000229

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155336	B. WIN			04/19/20	011
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	8			NCHER ROAD		
DECATU	IR TOWNSHIP CAR	RE AND REHABILITATION CENTE	:R	1	APOLIS, IN46221		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
	reviewed on 04/	18/2011 at 1:50 p.m. and			alarm to resident in the bed.		
	indicated the res	ident was originally			Resident B was re-evaluated by the	he	
	admitted to the f	acility on 12/08/2009 and			licensed nurse for falls upon		
		tted on 03/30/2011. The			re-admission on 3/30/11 with new interventions ordered for a low be		
	I -	ses included, but were			with mats and a room move close		
	1	phasia, cerebrovascular			the nursing station to increase	1 10	
	_				supervision.		
	disease, Alzheim	•			2. The Director of Nursing an	d	
		ures, stage IV breast			Assistant Director of Nursing aud	lited	
		cer, depressive disorder,			residents with a decline in condit	ion	
		mentia, and vitamin D			for a preventative plan of care for		
	deficiency.				falls with no other residents		
					identified to be affected at the cer	nter	
	Resident #B's m	ost recent significant			on 5/11. 3. The licensed nurses will be		
		n Data Set [MDS]			re-educated by the Director of		
	1	d 03/22/2011, indicated			Nursing and Assistant Director of		
		severely cognitively			Nursing by 5/6/11 on assuring		
		ily decision making			residents with a decline in conditi	ion	
	_	-			continue with a preventative fall	care	
		ar speech, was rarely			plan that will be reviewed to assi		
	understood and s				interventions are appropriate and	will	
		was being said. The			revise care plan as deemed		
	MDS assessmen	t indicated the resident			appropriate by the interdisciplina	ry	
	needed extensive	e assist of 1 person with			team. 4. The Director of Nursing an	<sub>d</sub>	
	bed mobility, tra	nsfers, ambulation,			Assistant Director of Nursing wil		
	dressing, eating,	toileting, hygiene, and			continue to monitor residents wit		
		ident was frequently			falls and residents with a decline		
		owel and bladder. The			condition 5x a week in the daily		
		eady decline in condition			morning meeting to assure the		
		of pain, being tired, poor			residents preventative fall care pl		
	_	loss, and increased			is updated with new interventions		
					the next 4 weeks and will re-eval		
	1 ~	oncentration, speaking,			in the next Monthly Performance Improvement meeting for any fur		
	and moving.				recommendations.	LIICI	
					5. Compliance Date 5/5/11.		
		ll Evaluation, dated					
	03/02/2011, indi	cated the resident was at					

NAME OF PROVIDER OR SUPPLIER  DECATUR TOWNSHIP CARE AND REHABILITATION CENTER  (X4) ID  SIMMARY STATEMENT OF DEFICIENCIES  TAG  REGULATORY OR ISC IDENTIFYING INFORMATION)  TISK for falls. Risk factors included, but were not limited to, a change in mobility, need for assistance with bed mobility, transfer or ambulation, resident wanders, has had changes in medications and new medications, and the resident weards glasses.  Resident #B's clinical record indicated the resident was admitted to Hospice services on 03/04/2011. The Hospice Nursing Narrative Summary dated 03/04/2011 indicated the patient was weak, had pain in bones, had grimacing, decreased appetite, refuses meals, decreased strength, increased mental status changes, was incontinent of bowel and bladder, was total care for all activities of daily living, and used a wheelchair for ambulation by staff.  The Hospice Nursing Summary indicated safety issues which included limited range of motion, bone or joint problems, bone pain, total assist, vision impaired, decreased endurance, fatigue, weakness, support needed during transfer and ambulation, bowel and bladder incontinence, precautions needed for scizures and falls.	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155336		l ,	IULTIPLE CO ILDING	ONSTRUCTION 00	COMPL	ETED	
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pain, total assist, vision impaired, decreased endurance, fatigue, weakness, support needed during transfer and ambulation, bowel and bladder incontinence, precautions needed for		safety issues whi	ch included limited range					
decreased endurance, fatigue, weakness, support needed during transfer and ambulation, bowel and bladder incontinence, precautions needed for			-					
support needed during transfer and ambulation, bowel and bladder incontinence, precautions needed for		-	_					
ambulation, bowel and bladder incontinence, precautions needed for			_					
incontinence, precautions needed for			_					
		· ·						
seizures and falls.		_						
		seizures and falls	5.					
Interdisciplinary Progress Notes dated		Interdisciplinary	Progress Notes dated					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155336			IULTIPLE COI ILDING	NSTRUCTION 00	COMPI	LETED	
		155336	B. WII			04/19/2	2011
	PROVIDER OR SUPPLIER	E AND REHABILITATION CEN	TED	4851 TII	DDRESS, CITY, STATE, ZIP CODE NCHER ROAD APOLIS, IN46221		
				<u> </u>			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI	i.	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		DATE
-		eated the resident					
		endently, is periodically					
	1	f will walk with her. The					
		he resident had not been					
		ntly and had been smiling					
	~	and being tired. The					
		ed to be feeling tired,					
	having a poor ap						
	concentrating, ar	nd moving less and so					
	slowly that other						
	Interdisciplinary	Progress Notes dated					
	03/25/2011 at 9 a	a.m. indicated the resident					
	had a grand mal	seizure while sitting in					
	wheelchair in ha	llway. "Resident					
	continually refus	ing meds over several					
	*	lated 03/26/2011 at 11					
	l *	e resident was up					
		oom into hallway					
	1 ^	rect res [resident] several					
		o bed due to gait					
	1	ed c [with] res c min.					
		to East Wing lounge et					
		n couch s [without]					
	difficulty."						
	Interdigainline	Dragragg Notes dated					
		Progress Notes dated 30 a.m. indicated the					
		ontinent of urine and care					
	light in reach.	positioned in bed and call					
	ngin in teach.						
	   Interdisciplinary	Progress Notes dated					
		45 a.m. indicated, "CNA					
	03/20/2011 at 4.	15 u.m. maicatea, Civi					

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Event ID:

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155336	A. BUI	ILDING	NSTRUCTION 00		X3) DATE S COMPLI <b>04/19/2</b> (	ETED
		100000	B. WIN				0-7/13/20	711
NAME OF I	PROVIDER OR SUPPLIER	8		1	DDRESS, CITY, STAT NCHER ROAD	E, ZIP CODE		
DECATU	R TOWNSHIP CAR	RE AND REHABILITATION CEI	NTER	1	APOLIS, IN46221	I		
(X4) ID		STATEMENT OF DEFICIENCIES		ID		AN OF CORRECTION		(X5)
PREFIX	` ·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE O TO THE APPROPRIATE IENCY)	≣	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFIC	IENCY)		DATE
		into room et [and] found						
		or on her back next to bed						
	•	forehead et blood on her						
		the floor. Res eyes open						
		this writer. Res moaned						
	•	this writer touched her						
		nurse called into room.						
		s writer. BP [blood						
	pressure] 118/80							
		. Res had black and blue						
	` ' [ U ] ]	t swollen." Further notes						
		ident was sent to the						
	_	ily and physician were						
		dated 03/28/2011 at 11						
		e resident was admitted						
	to the hospital w	ith a brain hemorrhage.						
	Hospital records	dated 03/28/2011						
	indicated, " EC	CF [extended care facility]						
	resident fell dow	n this morning striking						
	her head. She w	as found by staff down on						
	the ground and v	vas uncertain exact						
	timeframe. Patie	ent does have chronic						
	dementia and me	etastatic breast cancer						
	stage IV Pat	ient received CT of her						
	head demonstrat	ing parenchmal bleed,						
	subdural hemato	ma"						
	TI DI :: 5	. 1 0 1.1						
	· ·	ischarge Summary dated						
		cated discharge diagnoses						
		eed, Alzheimer's						
		cancer with bony						
	metastasis.							
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	NBHR1	1 Facility I	D: 000229	If continuation she	eet Pac	ne 6 of 16

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155336	ĺ	ILDING	NSTRUCTION  00	(X3) DATE COMPI 04/19/2	LETED
	PROVIDER OR SUPPLIER	II E AND REHABILITATION CENT	1	STREET A	DDRESS, CITY, STATE, ZIP CODE NCHER ROAD APOLIS, IN46221		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	fall risk related to limited mobility, psychotropic dru 12/17/09 and rec 03/28/2011 with bed," indicated a following: moni changes in behave agitation, declined keep call bell with remind to call for s/sx of UTIs or oprovide resident provide well lit, provide assist for engage resident in activity programmused objects with resident for chand mental status, more medication side of and/or orthostatic bedside was added pressure alarm to added 03/28/201 subdural hemator.	tor and document for vior, such as increased in mental status, etc.; thin reach of resident, r assistance; monitor for other infectious process; with clean glasses daily; clutter free environment; r toileting as needed; in active participation in ming; keep frequently min reach; evaluate ge in vision, change in eed medication, effects, gait disturbance, c hypertension; strips at eed on 06/28/10; and o bed at all times was 1 after the fall with the					
	at 2:30 p.m. indic the fall included and CNA who cl	inistrator on 04/18/2011 cated the investigation of interviewing the nurse aimed they had just esident 5 minutes prior to					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED	
		155336	B. WING		04/19/2011
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE NCHER ROAD	
DECATU	R TOWNSHIP CAR	E AND REHABILITATION CENTER		APOLIS, IN46221	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
IAG	the fall and she w	· · · · · · · · · · · · · · · · · · ·	IAG		DAIL
	the full that she v	vus IIIIe.			
	on 04/19/2011 at their investigation and the DoN pull which showed the not thoroughly in the above document the resident, not achecks as the Dofacility failed to for a resident who declining conditions falling out of bed	ne DoN and Administrator 11:50 a.m. indicated n was in the computer led off the documentation e unwitnessed fall was nvestigated, but supported entation of a lapse of 1 lates between checks on 5 minutes between N had thought. The implement interventions o was in an active on to prevent her from I and having received a trauma - subdural			
	This Federal tag IN00088825.	is related to Complaint			
	3.1-45(a)(1) 3.1-45(a)(2)				
F9999					
1 2227	State Finding:	n in mann ann illia Com de c	F9999	"This Plan of Correction is prepared and submitted as required by law. By submitting	05/09/2011
	overall management shall not function	r is responsible for the nent of the facility but as a departmental cample, director of		this Plan of Correction, <b>Decate Care &amp; Rehabilitation Center</b> does not admit that the deficie listed on this form exist, nor do the Center admit to any	ncy

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155336			A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE S COMPL 04/19/2	ETED
	PROVIDER OR SUPPLIER	IL RE AND REHABILITATION CENT		STREET A	NCHER ROAD APOLIS, IN46221		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	the same hours. the administrator limited to, the for (1) Imm division by telep notice within two (24) hour occurrences that welfare, safety, oresident or reside limited to any:  If the de reached, such as a call shall be more telephone numbed division.  This State Rule with by:  Based on observer record review, the to the Indiana State [ISDH] a fall with for 1 of 3 resident	ediately informing the hone, followed by written enty-four rs, of unusual directly threaten the or health of the ents, including, but not  (A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents. partment cannot be on holidays or weekends, ade to the emergency er ((317) 383-6144) of the was not met as evidenced  ation, interview, and he facility failed to report ate Department of Health th significant head injury has reviewed for falls and rting of significant injury [Resident #B]			statements, findings, facts, or conclusions that form the basi for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basi for the deficiency."Criteria for determination of a significant injury has been put into place the staff educated. Any injury which there is a laceration or bruise that exceeds 8cm, it mube measured, documented an reported to Director of Nursing and the Administrator so they may report it to the state. 1. The Administrator or Director of Nursing will review any incident 5x a week for the next 4 week the morning meeting and will re-evaluate in the next Performance Improvement Committee Meeting for any further recommendations.2. The Administrator and Director of Nursing were re-educated by Regional Director of Clinical Operations on the Indiana State portable requirements on 5/2/11.3. The Administrator and Director of Nursing or supervisivill report according to the Indiana State guidelines effect immediately on 5/2/11. 4. The licensed nurses were re-educated by the Director of Nursing and Assistant Director of Nursing and Assistant Director of Nursing. The license nurse will report	s with in ust d grant in the the te end sor tive e ated nes	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:  155336		A. BUI	LDING	ONSTRUCTION  00	(X3) DATE S COMPL <b>04/19/2</b> (	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	{		4851 TI	NCHER ROAD		
DECATU	IR TOWNSHIP CAF	RE AND REHABILITATION CENT	ER	INDIAN	APOLIS, IN46221		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		NCY MUST BE PERCEDED BY FULL SELSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	re l	COMPLETION DATE
TAG	Resident #B was at 10:35 a.m. to nurse's station in East Wing. The have a fading br and right cheek Interview with the Nursing [ADoN a.m. indicated R about three weel hospital with an The ADoN indicated the resident and dementia and total care.  Resident #B's clareviewed on 04/ indicated the resident's diagnor not limited to the frecently re-admit resident's diagnor not limited to, and disease, Alzheim convulsions/seiz cancer, bone care hypertension, dedeficiency.  Resident #B's mechange Minimum at 10:35 a.m. to any any and a deficiency.	the Assistant Director of on 04/18/2011 at 10:35 esident #B had fallen as ago and was sent to the intracranial hemorrhage. Eated the resident was a t, was not interviewable, d breast cancer, and was inical record was 18/2011 at 1:50 p.m. and ident was originally facility on 12/08/2009 and tted on 03/30/2011. The oses included, but were obasia, cerebrovascular		TAG	immediately to the Administrator/Director of Nursi or the supervisor of any unusu occurrences that directly threa the welfare, safety, or health of the resident or residents. The Administrator, Director of Nursing, or supervisor will their report to ISDH per guidelines in notification.	ial ten f	DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155336		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE S COMPL 04/19/2	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	<b>"</b> {	_	1	DDRESS, CITY, STATE, ZIP CODE		
DECATU	IR TOWNSHIP CAF	RE AND REHABILITATION CENT	ER	1	NCHER ROAD APOLIS, IN46221		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	impaired with day skills, had uncles understood and sunderstand what MDS assessmen needed extensive bed mobility, tradressing, eating, bathing. The resident had a stewith complaints appetite, weight problems with complaints appetite, weight problems with cand moving.  The Resident Fa 03/02/2011, indivisk for falls. Rivere not limited change in gait, coneed for assistant transfer or ambutincontinent and wanders, has had and new medical wears glasses.  Resident #B's claresident was adnot 03/04/2011.  Narrative Summ	severely cognitively ally decision making ar speech, was rarely sometimes could was being said. The trindicated the resident erasist of 1 person with ansfers, ambulation, toileting, hygiene, and sident was frequently owel and bladder. The ready decline in condition of pain, being tired, poor loss, and increased concentration, speaking,  Il Evaluation, dated cated the resident was at sk factors included, but to, a change in mobility, hange in transfer ability, are with bed mobility, lation, resident is confused, resident dichanges in medications tions, and the resident  Initial record indicated the mitted to Hospice Services The Hospice Nursing ary dated 03/04/2011 lient was weak, had pain					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155336		<u> </u>	IULTIPLE CON	NSTRUCTION 00	CO	ATE SURVEY MPLETED	
		100330	B. WIN				9/2011
	PROVIDER OR SUPPLIER			4851 TIN	DDRESS, CITY, STATE, ZIP COD NCHER ROAD	Έ	
		E AND REHABILITATION CENT	ER	INDIANA	APOLIS, IN46221		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	appetite, refuses strength, increase was incontinent of was total care for living, and used a ambulation by sta	ed mental status changes, of bowel and bladder, all activities of daily a wheelchair for aff.					
	of motion, bone of pain, total assist, decreased endura support needed d ambulation, bow	unce, fatigue, weakness, uring transfer and el and bladder cautions needed for					
	03/09/2011 indic ambulated indepe unsteady, so staff notes indicated the feeling well received less due to pain a resident was noted having a poor app	endently, is periodically f will walk with her. The ne resident had not been ntly and had been smiling and being tired. The ed to be feeling tired, petite, trouble d moving less and so					
	03/25/2011 at 9 a	Progress Notes dated a.m. indicated the resident seizure while sitting in lway. "Resident					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155336	A. BU	ILDING	NSTRUCTION  00	(X3) DATE COMPI 04/19/2	LETED		
NAME OF PROVIDER OR SUPPLIER  DECATUR TOWNSHIP CARE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  4851 TINCHER ROAD					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	S-REFERENCED TO THE APPROPRIATE			
	R TOWNSHIP CARE AND REHABILITATION CENT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL								

	A. BUILDING	00		(X3) DATE SURVEY  COMPLETED			
155336	B. WING		—   04/19/2	04/19/2011			
NAME OF PROVIDER OR SUPPLIER  DECATUR TOWNSHIP CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  4851 TINCHER ROAD  ER INDIANAPOLIS, IN46221				
SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			PPROPRIATE	DATE			
or and document for or, such as increased on mental status, etc.; in reach of resident, assistance; monitor for the infectious process; ith clean glasses daily;							
	AND REHABILITATION CENTER TEMENT OF DEFICIENCIES MUST BE PERCEDED BY FULL CIDENTIFYING INFORMATION)  The a brain hemorrhage.  The ded 03/28/2011  [extended care facility] Ithis morning striking If found by staff down on a uncertain exact It does have chronic It received CT of her It parenchmal bleed, It is parenchmal	AND REHABILITATION CENTER  TEMENT OF DEFICIENCIES TO A brain hemorrhage.  The atted 03/28/2011  [extended care facility] This morning striking found by staff down on suncertain exact to does have chronic static breast cancer ant received CT of her g parenchmal bleed, a"  Charge Summary dated ded discharge diagnoses d, Alzheimer's uncer with bony  plan for problem of weakness, unsteadiness, mpaired cognition, use with onset date of attly updated on fall unwitnessed out of foroaches of the r and document for or, such as increased an mental status, etc.; an reach of resident, assistance; monitor for er infectious process; atth clean glasses daily;	AND REHABILITATION CENTER  STREET ADDRESS, CITY, STATE, ZIP CO 4881 TINCHER ROAD INDIANAPOLIS, IN46221  TEMENT OF DEFICIENCIES MUST BE PERCEDED BY FULL CIDENTIFYING INFORMATION) This a brain hemorrhage.  Atted 03/28/2011  [extended care facility] this morning striking found by staff down on suncertain exact to does have chronic static breast cancer and received CT of her g parenchmal bleed, a"  Charge Summary dated ed discharge diagnoses d, Alzheimer's uncer with bony  plan for problem of weakness, unsteadiness, mpaired cognition, use with onset date of tity updated on all unwitnessed out of broaches of the r and document for or, such as increased n mental status, etc.; in reach of resident, assistance; monitor for er infectious process; ith clean glasses daily;	AND REHABILITATION CENTER  AND REHABILITATION CENTER  INDIANAPOLIS, IN46221  ITEMENT OF DEFICIENCIES  INDIANAPOLIS, IN46221  ITEMENT OF DEFICIENCIES  INDIANAPOLIS, IN46221  INDIANAPOL			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	COMPI			
155336		A. BUILDING B. WING		04/19/2011				
					DDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER				4851 TINCHER ROAD				
DECATU	R TOWNSHIP CAR	E AND REHABILITATION CENT	ΓER	INDIAN	APOLIS, IN46221			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  DECLE ATONY OR LSC INSTITUTION ATTONY  OF THE STATEMENT OF THE S			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROL TAG DEFICIENCY)				
PREFIX TAG						ATE	COMPLETION  DATE	
IAG	provide assist for toileting as needed;			IAG	BEITELENETY		DATE	
	l *	in active participation in						
	~~	ming; keep frequently						
		nin reach; evaluate						
	I -	ge in vision, change in						
	mental status, me	_						
	· ·	effects, gait disturbance,						
	and/or orthostation	c hypertension; strips at						
	bedside was add	ed on 06/28/10; and						
	pressure alarm to	bed at all times was						
	added 03/28/2011 after the fall with the							
	subdural hemato	ma.						
		ne Director of Nursing						
	[DoN] and Administrator on 04/18/2011							
	1 ^	cated the investigation of						
		interviewing the nurse						
		aimed they had just						
	checked on the resident 5 minutes prior to							
	the fall and she was fine.							
	Intomious with the Advisinistants							
	Interview with the Administrator on 04/19/2011 at 9:45 a.m. indicated the							
	facility uses the Reportable Unusual							
	Occurrences policy used by ISDH for their reportables. The policy indicates							
	"All unusual occurrences reported to the							
	Indiana State Department of Health will							
	be recorded and tracked or monitored to							
		are receiving appropriate						
	care and services." The policy indicated							
		required by law to report						
	unusual occurrences within 24 hours of							
	occurrence to the Long Term Care							
		<del>-</del>						

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AND PLAN OF CORRECTION IDENT		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  00			(X3) DATE SURVEY COMPLETED	
		155336	- 1	LDING		04/19/20		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER				4851 TI	NCHER ROAD			
DECATU	R TOWNSHIP CAR	E AND REHABILITATION CENT	ER	INDIAN	APOLIS, IN46221			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE	
1710		ghly investigate, and the	+	1710	•		DATE	
		estigation must be						
	reported to ISDH in writing for by fax							
	•	days of the occurrence.						
		e Administrator on						
		30 p.m. indicated the						
	-	portables since the last						
	surveyor was in o	*						
	investigation on March 26, 2011.							
	Interview with the DoN and Administrator							
	on 04/19/2011 at 11:50 a.m. indicated							
	their investigation was in the computer							
	and the DoN pulled off the documentation							
	which showed the unwitnessed fall was							
	not thoroughly in	vestigated, but supported						
	the above documentation of a lapse of 1							
	hour and 15 minutes between checks on the resident, not 5 minutes between checks as the DoN had thought. The facility failed to implement interventions for a resident who was in an active declining condition to prevent her from falling out of bed and having received a							
	-	rauma - subdural						
	hematoma.	rauma - Subdurar						
	This State Rule f	inding relates to						
	Complaint IN000	_						
	3.1-13(g)(1)							